233042

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR — REG. NO. 8 5 2 2 9 2 8

1. DECEASED NAME (TYPE OR PRINT): FIRST Michael (MICHAEL) MIDDLE Patrick (PATRICK) LAST Adams (ADAMS)

2a. DATE OF DEATH — KNOWN ☐ ESTIMATED ☒ MONTH 8 DAY 15 YEAR 1985 — 2b. HOUR 4 P.M.

3. SEX M — 4. RACE W — 5. DATE OF BIRTH MONTH DAY YEAR 9/28/59 — 6. AGE (IN YEARS LAST BIRTHDAY) 25 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD MONTH 8 DAY 15 YEAR 1985 — 2d. HOUR 9 P.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Wash., D. C.

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Charles MD.

10. CITY OR TOWN OF DEATH: La Plata

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Physicians Memorial Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Driver/Mechanic

12b. KIND OF BUSINESS OR INDUSTRY: Constructio

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD — 13b. COUNTY: Charles — 13c. CITY OR TOWN: Waldorf — 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET ADDRESS: P. O. Box 386 20601

14. FATHER'S NAME: FIRST Joseph MIDDLE Raymond LAST Adams

15. MOTHER'S MAIDEN NAME: FIRST Katie MIDDLE B. LAST McBee

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES): ----------

16b. SOCIAL SECURITY NO.: 217-72-9962

17. INFORMANT: wife — ADDRESS: Teresa A. Adams same as 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Gunshot wound to chest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: instantaneous

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): ____

DUE TO, OR AS A CONSEQUENCE OF (c): ____

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION: ____

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? ____

20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. ☒ P.M. ☐ MONTH DAY YEAR 6 A.M. 15 August 1985

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Gunshot wound

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): home

21f. LOCATION STREET: Rt 925 CITY OR TOWN: Waldorf COUNTY: Charles STATE: Md

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE ____ M.D. ____ TITLE (SPECIFY) MEDICAL EXAMINER — DATE SIGNED 15 August 1985

EXAMINER'S NAME (TYPE OR PRINT): H.M. Mahan, Hall MD — ADDRESS: SR#1 Box 1020 LaPlata, Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 8/17/85 — 23c. NAME OF CEMETERY OR CREMATORY: Resurrection Cem. — 23d. LOCATION CITY OR TOWN: Clinton COUNTY: Pr. Geo., STATE: MD

24. FUNERAL DIRECTOR NAME AND ADDRESS: Huntt Funeral Home, Waldorf, MD

25a. DATE REC'D. BY REGISTRAR: AUG 19 1985 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH SUBPOENA PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP ____ DHMH - 17 (VR A15 ME (5))

238148

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 22929
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove blank page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the case.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	ESTELLE / CIARA / CLARK	2a. DATE OF DEATH MONTH / DAY / YEAR	8 / 14 / 85
		2b. HOUR	10 14 A M
3. SEX	F	4. RACE	B
5. DATE OF BIRTH MONTH / DAY / YEAR	1 / 19 / 26	6. AGE (IN YEARS LAST BIRTHDAY)	59 YRS
IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	MARYLAND	7b. CITIZEN OF WHAT COUNTRY?	UNITED STATES
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]		9. BALTIMORE CITY OR COUNTY OF DEATH	CHARLES COUNTY MD.
10. CITY OR TOWN OF DEATH	LA PLATA MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	PHYSICIANS MEMORIAL HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	DOMESTIC WORK	12b. KIND OF BUSINESS OR INDUSTRY	PRIVATE
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	MD	13b. COUNTY	Charles
13c. CITY OR TOWN	NEWBURG	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	
13e. STREET ADDRESS / ZIP CODE	SHALLOW Church RD 20664		
14. FATHER'S NAME FIRST / MIDDLE / LAST	WILLIAM / HENRY / WAUGH	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	MARY / E. / WASHINGTON
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	NO	(IF YES, GIVE WAR OR DATES)	N/A
16b. SOCIAL SECURITY NO	217306991	17. INFORMANT ADDRESS	JOHN CLARK, RT.1 BOX 143 NEWBURG, MD. 20664

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Massive Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b) Advanced Atherosclerotic Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES [ ] NO [X]		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]	
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE			

22a. I certify that (I) (this hospital) attended the deceased from 1981, 19__, to 8/14, 1985, that (I) (we) last saw the deceased alive on 8/14, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] — 22c. DATE SIGNED 8/14/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT) E.J. WATSON, M.D. George Watson — 22e. ADDRESS LA PLATA, Md 20646

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	BURIAL	23b. DATE	AUG. 19, 85	
23c. NAME OF CEMETERY OR CREMATORY	SHILOH CHURCH CEM.	23d. LOCATION CITY OR TOWN / COUNTY / STATE	NEWBURG	CHARLES MD.
24. FUNERAL DIRECTOR	THORNTON'S FUNERAL HOME	ADDRESS	POMONKEY, MD.	
25a. DATE REC'D. BY REGISTRAR	AUG 19 1985	25b. REGISTRAR'S SIGNATURE		

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

238012

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 2 2 7 3 0

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 28. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS - 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST	James	MIDDLE	B	LAST	Dorsey	2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☒ MONTH	8	DAY 11 YEAR 1985	2b. HOUR 3:00 AM
3. SEX	M	4. RACE	B	5. DATE OF BIRTH MONTH 3 DAY 25 YEAR 59	6. AGE (IN YEARS LAST BIRTHDAY) 26 YRS.	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD MONTH 8 DAY 11 YEAR 1985	2d. HOUR 3:26 AM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	MARYLAND	7b. CITIZEN OF WHAT COUNTRY?	UNITED STATES	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐		9. BALTIMORE CITY OR COUNTY OF DEATH	CHARLES COUNTY MD.		
10. CITY OR TOWN OF DEATH	LA PLATA	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	PHYSICIANS MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	LABORER	12b. KIND OF BUSINESS OR INDUSTRY	PRIVATE		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	MARYLAND	13b. COUNTY	CHARLES	13c. CITY OR TOWN	BEL ALTON	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS	FAIRGROUND ROAD	20611
14. FATHER'S NAME FIRST	JOHN	MIDDLE		LAST	DORSEY	15. MOTHER'S MAIDEN NAME FIRST	ESTELLE	MIDDLE	LAST HAWKINS
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	NO	(IF YES, GIVE WAR OR DATES)	N/A	16b. SOCIAL SECURITY NO.	212-80-9458	17. INFORMANT	JOHN DORSEY - GENERAL DELIVERY	ADDRESS	BEL ALTON, MD. 20611

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8147 IMMEDIATE CAUSE (a)	Craniocerebral trauma	instant
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3:00 A.M. 11 August 1985	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) struck by car
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Street	21f. LOCATION STREET Fairground Rd CITY OR TOWN Bel Alton COUNTY Charles STATE MD

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE H.M. Mahar M.D. TITLE (SPECIFY) Chief Co MEDICAL EXAMINER DATE SIGNED 11 Aug 85

EXAMINER'S NAME (TYPE OR PRINT) H.M. Mahar. Haft MD ADDRESS 5RHy Box 100 LaPlata MD 20646

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
BURIAL	AUG. 14,85	ST. MATTHEWS CH. CEM.	NEWTOWN	CHARLES	MD.

24. FUNERAL DIRECTOR NAME / ADDRESS THORNTON'S FUNERAL HOME POMONKEY, MD.

25a. DATE ACCEPTED BY REGISTRAR AUG 19 1985 25b. REGISTRAR'S SIGNATURE Julia Davidson Registrar

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

220024

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 85 22931

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT) FIRST: ROY MIDDLE: Wilfred LAST: FORREST				2a. DATE OF DEATH MONTH DAY YEAR: August 4,1985	2b. HOUR: 2:38P.M.
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: Apr. 13, 1908		6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): PA	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐		9. BALTIMORE CITY OR COUNTY OF DEATH: Charles MD.	
10. CITY OR TOWN OF DEATH: LaPlata,	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Physicians Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Meat buyer	12b. KIND OF BUSINESS OR INDUSTRY: Grocery

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD	Charles	Waldorf	YES ☐ NO ☒	909 Fowler Court 20601

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Roy / Sydney / Forrest	Etta / Rittenoir

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	----------	191-01-0562	Frances Forrest	same as 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) Coronary Heart Disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from May, 1980, to 8-4-1985, that (I) (~~me~~) last saw the deceased alive on JUNE 1985, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~me~~) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	M.D. ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	August 4,85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Dr. G. Rath	Chas. Prof. Bldg., Waldorf, Md. 20601

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	8/7/85	Trinity Mem. Gardens	Waldorf Charles MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE RECD. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Huntt Funeral Home	P.O. Box 156 Waldorf, Md. 20601	AUG 6 1985	[signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be delivered to the local registrar within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

238082

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 22932

1. DECEASED NAME (TYPE OR PRINT) — FIRST / MIDDLE / LAST	Bruce	Bernard	Garner
2a. DATE OF DEATH — MONTH / DAY / YEAR	Aug	14	1985
2b. HOUR	4:20 P M		
3. SEX	MALE		
4. RACE	WHITE		
5. DATE OF BIRTH — MONTH / DAY / YEAR	JUNE	1,	1918
6. AGE (IN YEARS LAST BIRTHDAY)	67 YRS		
IF UNDER 1 YEAR — MONTHS / DAYS			
IF UNDER 24 HRS — HOURS / MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	MARYLAND		
7b. CITIZEN OF WHAT COUNTRY?	U.S.A.		
8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐			
9. BALTIMORE CITY OR COUNTY OF DEATH	Charles		MD.
10. CITY OR TOWN OF DEATH	La Plata		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Physicians Memorial Hospital		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	HOME REPAIRMAN		
12b. KIND OF BUSINESS OR INDUSTRY	SELF-EMPLOY		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD.	CHARLES	HUGHESVILLE	YES ☐ NO XX	RT.#1 BOX 416 20637

14. FATHER'S NAME — FIRST / MIDDLE / LAST	RICHARD	Alexander	GARNER	15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST	ELIZABETH	HARRIET	WELCH

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
YES	WWII	217-14-7002	BESSIE WELCH / SAME AS #13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral Hemorrhage

DUE TO, OR AS A CONSEQUENCE OF

(b) Hypertension

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Chronic Obstructive Pulmonary Disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY — HOUR A.M. P.M. / MONTH / DAY / YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____ to 8-14 19 85, that (I) (we) last saw the deceased alive on 8-14 19 85, and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐	22c. DATE SIGNED
Henry L. Burke MD		8-14-85
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS	
Henry L. Burke M.D	La Plata, MD 20646	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION — CITY OR TOWN / COUNTY / STATE	
BURIAL	8-16-85	MD. VETERANS CEM.	CHELTENHAM	P.G. MD.

24. FUNERAL DIRECTOR — NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
AREHART FUNERAL HOME, INC. LA PLATA, MD.	AUG 19 1985	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal from the state, unless a permit has been issued by the medical examiner, coroner or medical examiner.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner, coroner or medical examiner must be notified before any action is taken.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 85 22933

228005

1 - FOR STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST				2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Douglas (NMN) Henderson				August 11, 1985	10:20 P.M.
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
MALE	Caucasian	June 1, 1922	63 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH		
West Va.	USA		Charles		MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
La Plata	Physicians Memorial Hospital		Driver	Newspaper	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD	Charles	Port Tobacco	YES ☐ NO ☒	P. O. Box 1147B 20677

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Thomas Henderson	Unknown

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	1947-1963	235-26-1706	Son	Thomas Henderson same as 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute Pulmonary Embolism,	
DUE TO, OR AS A CONSEQUENCE OF (b)	Acute Lateral Myocardial Infarction,	
DUE TO, OR AS A CONSEQUENCE OF (c)	Diabetes Mellitus Type II,	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 8/11, 19 85, to 8/11, 19 85, that (I) (we) last saw the deceased alive on 8/11, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	8/12/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
George Wathen, M.D.	La Plata, Md. 20646

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	8/13/85	Huntt Crematory	Waldorf Charles MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Huntt Funeral Home, Waldorf, MD	AUG 14 1985	[signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

227084

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 22934

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT) FIRST: VEDA	MIDDLE: ELAINE	LAST: HAMMEY	2a. DATE OF DEATH MONTH DAY YEAR: Aug. 3 1985	2b. HOUR: 4P M	
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: OCT. 21, 1904	6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U. S. of A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Charles County, MD.		
10. CITY OR TOWN OF DEATH: Cobb Island	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 33 S.E. Crain Blvd.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Salesperson-Ret. Dept. Store	12b. KIND OF BUSINESS OR INDUSTRY		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Charles	Cobb Island	YES ☐ NO ☒	33 S.E. Crain Blvd. 20625

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Edward Hoffman	Nancy Replage	No	577-38-5018	Patricia A. Walton 10424 Windsor View Potomac, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Art. Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b): Atherosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes Mell, Tus, Carcinoma of Colon, Metastatic

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) this hospital) attended the deceased from ____ 19____, to Aug 3 19 85, that (I) (we) last saw the deceased alive on July 30 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Henry L Burke MD — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 8-3-85

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Henry L. Burke, M.D. — 22e. ADDRESS: La Plata, Maryland 20646

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	08/06/85	Ft. Lincoln	Brentwood P.G. Md.

24. FUNERAL DIRECTOR NAME / ADDRESS: AREHART FUNERAL HOME, INC., LA PLATA, MD.

25a. DATE REC'D. BY REGISTRAR: AUG 12 1985

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local registrar of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

239014

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 8 2 2 1 3 5

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEMS GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17 20M 1/73 (VR A15 ME (5))

1. DECEASED NAME (TYPE OR PRINT)	FIRST: DONALD (Donald)	MIDDLE: PATRICK (P.)	LAST: MORGAN (Morgan)	2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☐	MONTH: 8	DAY: 15	YEAR: 1985	2b. HOUR: 10:00 A M
3. SEX: M	4. RACE: W	5. DATE OF BIRTH: MONTH 3 DAY 19 YEAR 63	6. AGE (IN YEARS LAST BIRTHDAY): 22 YRS.	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD: MONTH 8 DAY 15 YEAR 1985		2d. HOUR: 12:46 P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): California	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Charles MD.					
10. CITY OR TOWN OF DEATH: Indian Head	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): #148 Jenkins Lane	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Student	12b. KIND OF BUSINESS OR INDUSTRY: School					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: Charles	13c. CITY OR TOWN: Indian Head	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: Rt 1 Box 148	20640			
14. FATHER'S NAME: FIRST Ralph MIDDLE F. LAST Morgan	15. MOTHER'S MAIDEN NAME: FIRST Antoinette MIDDLE LAST Smith							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 213-90-7403	17. INFORMANT: Ralph F. Morgan	ADDRESS: 140 Jenkins Ln. Indian Head, Md					

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Strangulation
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): hanging
DUE TO, OR AS A CONSEQUENCE OF (c): suicide
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 20 min

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: David N. Gingrich M.D. TITLE (SPECIFY): Assistant Deputy MEDICAL EXAMINER DATE SIGNED: 8/15/85

EXAMINER'S NAME (TYPE OR PRINT): DAvid N. Gingrich ADDRESS: 5019 Woodhaven Dr. LaPlata MD 20646

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: 8/17/85	23c. NAME OF CEMETERY OR CREMATORY: Huntt Crematorium	23d. LOCATION CITY OR TOWN: Waldorf	COUNTY: Charles STATE: Md.
24. FUNERAL DIRECTOR NAME: Huntt Funeral Home ADDRESS: P. O. Box 156 Waldorf, Md 20601		25a. DATE REC'D. BY REGISTRAR: AUG 19 1985	25b. REGISTRAR'S SIGNATURE: [illegible]	

238141

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 22936

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 2, and 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Page 2 may be retained by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Albert	MIDDLE: Harold	LAST: Plant	2a. DATE OF DEATH MONTH DAY YEAR: 8 16 85	2b. HOUR: 11 A.M.
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Aug. 18, 1922	6. AGE (IN YEARS LAST BIRTHDAY): 62 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Penn	7b. CITIZEN OF WHAT COUNTRY?: U.S	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Charles MD.	
10. CITY OR TOWN OF DEATH: Waldorf	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 2202 Green Arbor Ct.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Instrument Foreman	12b. KIND OF BUSINESS OR INDUSTRY	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Md	Charles	Waldorf	YES ☑ NO ☐	2202 Green Arbor Ct 20601

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Albert / / Plant	Beatrice / Ethel / Walker

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW II	191-22-962	Iris, Plant (wife)	2202 Green Arbor Ct.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Amyotrophic Lateral Sclerosis

DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory Failure

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1979, 19___, to 8/16, 1985 that (I) (we) last saw the deceased alive on 8/16, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	8/16/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
WATHEN	Waldorf md. 21140

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	8-19-85	Stonington Mem. Pk	Stonington, Northumberland Pa.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Huntt Funeral Home	P. O. Box 156 Waldorf, Md. 20601	AUG 19 1985	Julia Davidson Randall

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

246086

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 22937

1. DECEASED NAME (TYPE OR PRINT): FIRST Dennis; MIDDLE Patrick; LAST Reese

2a. DATE OF DEATH: KNOWN XX / ESTIMATED ☐ — MONTH 8 DAY 20 YEAR 1985

2b. HOUR —

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH: MONTH 4 DAY 16 YEAR 47

6. AGE (IN YEARS LAST BIRTHDAY): 38 YRS. IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: MONTH 8 DAY 20 YEAR 1985

2d. HOUR 11:56 a.m.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Ohio

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Charles County, MD

10. CITY OR TOWN OF DEATH: La Plata

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Physician's Memorial Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Contract Specialist

12b. KIND OF BUSINESS OR INDUSTRY: USGovt

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.

13b. COUNTY: Charles

13c. CITY OR TOWN: Waldorf

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS: 2017 Bainbridge Court Zip: 20601

14. FATHER'S NAME: FIRST Regis; MIDDLE John; LAST Reese

15. MOTHER'S MAIDEN NAME: FIRST Helen; MIDDLE Gertrude; LAST Holden

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES): Vietnam

16b. SOCIAL SECURITY NO.: 281-42-4502

17. INFORMANT: William Reese ADDRESS: 6301 Stevenson Ave. Alex., Va. 22304

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovascular Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO XX

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes XX, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Dennis F. Smyth M.D. TITLE (SPECIFY): Assistant MEDICAL EXAMINER DATE SIGNED 8-21-85

EXAMINER'S NAME (TYPE OR PRINT): Dennis F. Smyth, M.D. ADDRESS: 111 Penn St., Balto., Md. 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 8-23-85

23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery

23d. LOCATION CITY OR TOWN: Youngstown, COUNTY STATE: Ohio

24. FUNERAL DIRECTOR NAME: Fox Funeral Home ADDRESS: Youngstown, Ohio

25a. DATE REC'D. BY REGISTRAR: AUG 29 1985

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Pondelle

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS - 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

235048

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 85 22938

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
DOROTHY	ELIZABETH	STOLL	August 12, 1985	6:52A M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
Female	Caucasian	March 23, 1909	76 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.A.		Charles County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
LaPlata	Physicians Memorial Hospital	Homemaker	Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Charles	Waldorf	YES ☐ NO ☒	2004 Amber Leaf Place/20601

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
John	Phillip	Dorsey	Anna	Elizabeth	Jones

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	* * * *	578-14-5653	John A. Havenner	Bx45 St.Peter's Chr Waldorf,Md 20601Rd.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Nocardia Pneumonia.

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Pulmonary Fibrosis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 6-9- 19 83, to 8-12- 19 85. that (I) (we) last saw the deceased alive on 8-11- 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (~~provided~~) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
G.S.Rath	M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	8-12-85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
G.S. RATH. M.D.	CHAS. PROF. CTR. WALDORF, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	10/14/85	Trinity Mem. Gardens	Waldorf, Charles, Maryland

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Huntt Funeral Home	P. O. Box 56 Waldorf, Md.20601	AUG 14 1985	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

248034

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 22939
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please return the certificate papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	Winston Stewart Vines			2a. DATE OF DEATH MONTH DAY YEAR	8-27-85
				2b. HOUR	2:34 AM
3. SEX	Male	4. RACE	White	5. DATE OF BIRTH MONTH DAY YEAR	6-19-1936
6. AGE (IN YEARS LAST BIRTHDAY)	49 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	TENN.	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	
9. BALTIMORE CITY OR COUNTY OF DEATH	Charles MD.				
10. CITY OR TOWN OF DEATH	La Plata	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Physicians Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Carpenter
12b. KIND OF BUSINESS OR INDUSTRY	U.S.Govt.				

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD.	Charles	Nanjemoy	YES [ ] NO [X]	Rt.#1 Box 26-B2 20662

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Grover Vines	Bessie Timbs

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	1958	413-56-5785	Brenda Vines	Same As #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Acute interceptal infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) Cardio-respiratory shock

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 8-23, 19 85, to 8-26, 19 85, that (I) (we) last saw the deceased alive on 8-27, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Ignacio Garcia	MD	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	8-27-85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Ignacio Garcia, M.D.	Box K, La Plata, Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	8-29-85	Md. Vets. Cemetery	Cheltenham P.G. Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Arehart Funeral Home, Inc. La Plata, Md.	AUG 29 1985	Julia Davidson-Randall

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

256037

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 85 22940

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, all items completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and forward pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Samuel	MIDDLE: N/A	LAST: Washington	2a. DATE OF DEATH MONTH: August DAY YEAR: 08/31/1985		2b. HOUR: 6:15a M
3. SEX: male	4. RACE: black	5. DATE OF BIRTH MONTH DAY YEAR: 08/15/1887	6. AGE (IN YEARS LAST BIRTHDAY): 98 YRS	IF UNDER 1 YEAR MONTHS: 16 DAYS	IF UNDER 24 HRS HOURS: 6 MIN.: 15
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Charles MD.		
10. CITY, TOWN OF DEATH: La Plata	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Meridian Nursing Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): unknown	12b. KIND OF BUSINESS OR INDUSTRY: unknown		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Prince G.	13c. CITY OR TOWN: Clinton	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: 7704 Dundas Ct. 20735	
14. FATHER'S NAME FIRST: ~~not known~~	MIDDLE: George	LAST: Washington	15. MOTHER'S MAIDEN NAME FIRST: ~~not known~~	MIDDLE: Rebecca	LAST: Robinson
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 231-10-0787	17. INFORMANT: Clarence ~~Charles~~ H. Washington	ADDRESS: same as above	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): = Bronchitis & Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 mos

DUE TO, OR AS A CONSEQUENCE OF (b): Cancer of Lung — ?

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1-28 19 85 to 8-31 19 85 that (I) (we) last saw the deceased alive on 8-30 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 8-31-85

22d. PHYSICIAN'S NAME (TYPE OR PRINT) — 22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 9/4/85	23c. NAME OF CEMETERY OR CREMATORY: Resurrection	23d. LOCATION CITY OR TOWN: Clinton	COUNTY / STATE: P.G. Maryland
24. FUNERAL DIRECTOR NAME: Alexander S. Pope	ADDRESS: 2617 Pennsylvania Ave. S.E. Washington, DC.	25a. DATE REC'D. BY REGISTRAR: SEP - 9 1985	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

252062

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 22941
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: PAUL	MIDDLE: Crane	LAST: WEGNER, Sr.	2a. DATE OF DEATH MONTH: 8 DAY: 31 YEAR: 1985	2b. HOUR: 12:15a M	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH: 7 DAY: 28 YEAR: 1918	6. AGE (IN YEARS LAST BIRTHDAY): 67 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: CHARLES MD.		
10. CITY OR TOWN OF DEATH: LA PLATA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL GIVE STREET ADDRESS): PHYSICIANS MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Engineer Tec.	12b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Md.	Charles	Indian Head	YES [X] NO [ ]	2 Ridge Drive, 20640

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Adam	Herman	Wegner	Ethel	Daisy	Crane

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		169-05-7823	Helen	Wegner, Same as line 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute myocardial infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Hypertensive Cardiomyopathy

DUE TO, OR AS A CONSEQUENCE OF (c): Post-Cerebrovascular accident

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 6/10/81, 19____, to 8/31/85, 19____, that (I) (we) last saw the deceased alive on 6/18, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Ignacio T. Garcia, MD	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]	8-31-85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
IGNACIO GARCIA, M.D.	LA PLATA, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	9-1-85	Huntt Crematory	Waldorf, Charles Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Huntt Funeral Home, Waldorf, Maryland	SEP 5 1985	Gloria Davidson-Rinaldi

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

238048

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 22942

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Mae	Lillian	Wheeler	08-20-85	*8:00PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Female	White	06-05-02	83 YRS.	2	16	20	0

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED XX	9. BALTIMORE CITY OR COUNTY OF DEATH
Nokesville, Va.	U.S.		Charles County Maryland MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
LaPlata	Meridian Nursing Center	Acct. Clerk	U. S. Govt.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Montgomery	Wheaton	YES X NO ☐	10800 Georgia Avenue 20902

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Charles	Henry	Walter	Lillian		Payne

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	N/A	217-44-0645	Archie W. Conner P.O. Box 128 Marbury, M.D. 20656

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Probable Sepsis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Dehydration

DUE TO, OR AS A CONSEQUENCE OF (c) Organic Brain Syndrome

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 8/09 19 84 to 8/20 19 85 that (I) (we) last saw the deceased alive on 8/15/85 19 , and that in (my) (our) opinion death occurred at the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	8/26/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
[illegible]	LAPLATA, MD. 20646.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	8/23/85	Trinity Mem. Gardens	Waldorf, Charles, MD

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
The Huntt Funeral Home, Waldorf, MD	AUG 22 1985	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner shall be notified and shall determine whether an autopsy or further investigation is necessary.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 3 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

240093

FOR 1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8522943

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)	FIRST Steven	MIDDLE Bryon	LAST Winkler	2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐	MONTH 8	DAY 18	YEAR 1985	2b. HOUR 3:01 PM
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH 1 DAY 21 YEAR 67	6. AGE (IN YEARS LAST BIRTHDAY) 18 YRS.	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD	MONTH 8	DAY 18	YEAR 1985	2d. HOUR 3:01 PM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.

10. CITY OR TOWN OF DEATH La Plata	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic	12b. KIND OF BUSINESS OR INDUSTRY Auto

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE MD	13b. COUNTY Charles	13c. CITY OR TOWN Waldorf	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS 1025 Floyd Avenue 20601

14. FATHER'S NAME FIRST Steven	MIDDLE L.	LAST Winkler	15. MOTHER'S MAIDEN NAME FIRST Carol / MIDDLE Susan / LAST Drinks

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No	(IF YES, GIVE WAR OR DATES) ----------	16b. SOCIAL SECURITY NO. 214-08-2569	17. INFORMANT ADDRESS Steven L. Winkler, same as 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Craniocervical trauma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Instantaneous
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
8199

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. 3:01 MONTH 8 DAY 18 YEAR 1985	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Motor vehicle accident
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Street	21f. LOCATION STREET Middletown Rd CITY OR TOWN Waldorf COUNTY Charles STATE MD

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE H.M. Mahan Hoft MD — TITLE (SPECIFY) M.D. Charles Co. MEDICAL EXAMINER — DATE SIGNED 8/10/85

EXAMINER'S NAME (TYPE OR PRINT) H.M. Mahan Hoft MD — ADDRESS SR#1 Box 1020 LaPlata MD 20646

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8/22/85	23c. NAME OF CEMETERY OR CREMATORY Trinity Memorial Gardens	23d. LOCATION CITY OR TOWN Waldorf	COUNTY Charles STATE MD

24. FUNERAL DIRECTOR NAME / ADDRESS Huntt Funeral Home, Waldorf, MD 20601	25a. DATE REC'D. BY REGISTRAR AUG 21 1985	25b. REGISTRAR'S SIGNATURE Julia Davidson Randall	

BP____

DHMH - 17
(VR A15 ME (5))
20M 4/82